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## **Testimony in strong opposition to HB 6425 An Act Concerning Aid in Dying for Terminally Ill Patients February 26, 2021**

Senator Abrams, Representative Steinberg and members of the Public Health Committee:

I am an autistic adult and one of the leaders of Second Thoughts Connecticut, a coalition of disabled people opposed to the legalization of assisted suicide. Our group works with national disability rights organizations including Not Dead Yet and the Disability Rights Education and Defense Fund to oppose such legislation. Second Thoughts Connecticut is a member of the Connecticut Suicide Advisory Board. Personally, I serve on the board of directors of Euthanasia Prevention Coalition-USA and previously served on the Connecticut MOLST Task Force.

HB 6425 would codify lethal and systemic disability discrimination into law. It does so by redefining the suicides of a subset of disabled people as somehow not suicide, but a “medical treatment option,” using the focus-group-tested euphemism “aid in dying.”

Suicide is [defined](#) as the act of taking one’s life intentionally. The person who intentionally ingests a prescribed lethal overdose more closely fits the dictionary definition of suicide than the despondent person who jumps off a bridge. The desire for suicide is a cry for help, even when redefined as a “medical treatment option.”

The [Connecticut State Suicide Prevention Plan 2025](#) posits a clear intersection between assisted suicide and other suicide. Connecticut has the only comprehensive state suicide prevention plan that includes disabled people as a high-risk population. To quote the relevant section (pp. 57-58):

Discussions about assisted suicide for those with terminal illness intersect in important ways with suicide prevention. The active disability community in Connecticut has been vocal on the need for suicide prevention services for people with disabilities... [William] Peace writes that “Many assume that disability is a fate worse than death. So we admire people with a disability who want to die, and we shake our collective heads in confusion when they want to live.”

Connecticut’s suicide prevention plan makes a number of important recommendations, including “Do not assume suicide is a ‘rational’ response to disability or chronic illness.”

By contrast, [Oregon’s state suicide prevention plan](#) only deals with youth suicide—not adults of any age, and certainly not disabled people or older people as high-risk groups. A quarter

century of legalized assisted suicide in that state has led to a culture where the suicides of old, ill, and disabled people are viewed as mere “acceptable losses” by suicide prevention authorities—who all too often harbor ableist attitudes our state suicide prevention plan rejects.

In addition to attempting to redefine suicide, proponents of assisted suicide promote other falsehoods.

Proponents claim assisted suicide is only available to people who will soon die. Yet not only do many people far outlive “terminal” prognoses, [including those who have received lethal prescriptions](#), but many disabled people are perceived as “terminally ill” by medical professionals. Laws allow treatable medical conditions like [diabetes](#) to qualify as “terminal diseases,” and HB 6425 is no different, as the definition of “terminal illness” in Section 1 (20) does not say “regardless of treatment options.” Moreover, proponents have long sought to [expand suicide assistance to those with non-terminal disabilities](#).

They claim that their legislation is only for people in “deep and dire pain,” yet nothing in HB 6425 requires those seeking lethal overdoses to be in pain. Pain or the fear of it has never been in the top five reasons people give for seeking assisted suicide, according to Oregon’s annual reports. The overwhelming reasons people ask for assisted suicide involve [not wanting to live the way disabled people do](#).

Proponents claim that there have been no abuses in states that have legalized assisted suicide, when the [Disability Rights Education and Defense Fund](#) has documented a list of abuses and complications, including cases of prolonged and agonizing deaths. Moreover, as the Oregon Department of Health and Human Services stated: “We are not given the resources to investigate [assisted suicide cases] and not only do we not have the resources to do it, but we do not have any legal authority to insert ourselves.” The only reason more abuses have not been documented is that assisted suicide laws are designed to conceal them.

HB 6425 is actually worse than laws in other states by allowing both of the witnesses to the request for the lethal prescription to be family members, heirs, or employees of the health care facility where the patient resides, who can have a fiduciary interest in the patient’s earlier death. The 2015-2020 Connecticut assisted suicide bills that were rejected all forbade either witness from being in these categories. Along with the lack of any witness at the time of death, this provision is an open invitation to elder abuse. Other ostensible safeguards are overcome by doctor-shopping, which this bill makes easier than previous versions by allowing the attending and consulting physicians to work together in the same office.

Advocates claim to be about patient choice, yet there have been instances when insurance companies would pay for assisted suicide but not curative care. A state senator who serves on this committee and is a leading assisted suicide proponent authored an [op-ed](#) in the *Hartford Courant* proposing a separate bill that would “require the completion of advanced directives in order to sign up for Medicare, Medicaid or private health insurance.” He spoke of his proposal as a way of getting people to forgo curative care, thereby reducing healthcare costs. Proponents like to compare assisted suicide with pet euthanasia, but when we put animals down—[most of the time because they are unwanted or have behavior problems](#)—the animals do not get to choose. As the cheapest “treatment,” assisted suicide similarly

diminishes choice, and especially so for people of color, disabled people, and others who have been historically marginalized in our health care system.

Proponents demand legislation that mandates the falsification of death certificates. HB 6425 requires the underlying terminal illness be listed as the cause of death. If Connecticut follows the lead of Oregon and [Washington](#), this will forbid any mention of the lethal overdose. Connecticut's Division of Criminal Justice has twice submitted [testimony](#) in opposition to death certificate falsification, stating:

Section 9(b) effectively mandates the falsification of death certificates under certain circumstances. It states: "The person signing the qualified patient's death certificate shall list the underlying terminal illness as the cause of death." This is simply not the case; the actual cause of death would be the medication taken by or given to the patient... The practical problem for the criminal justice system and the courts will be confronting a potential Murder prosecution where the cause of death is not accurately reported on the death certificate.

Finally, there is the issue of further expansion. Some proponents may claim they only want a limited bill, but HB 6425 already guts some of the "safeguards" from previous bills. Moreover, we only need to look at what Compassion & Choices and other proponents are saying, and what bills they are pushing in other states. We can all remember when Compassion & Choices' president emerita Barbara Coombs Lee came to Hartford in October 2014 declaring support for assisted suicide for people with dementia and cognitive disabilities unable to consent; in her words, ["It is an issue for another day but is no less compelling."](#)

We can also look at current expansion legislation being pushed by Compassion & Choices in other states, particularly those in states that already have legalized assisted suicide, including [Oregon](#) (which already has expanded its law), [Washington](#), California, and [Hawaii](#), as well as bills in [New Mexico](#). These bills have provisions that would dramatically shorten and/or waive the mandatory waiting period, allow APRNs and PAs to prescribe lethal drugs, waive the requirement for a second doctor to confirm the ostensibly terminal diagnosis, allow almost anyone who does counseling for a fee to qualify in the rare case that the patient is referred for a mental health evaluation, allow mail-order delivery of lethal overdoses, and compel objecting providers to refer patients to other providers who will dispense lethal prescriptions.

This last provision, which is in [California SB 380](#), is a threat to patient safety, as noted by the example of [Jeanette Hall](#), who sought to die under Oregon's law but was persuaded by her doctor to accept cancer treatment and is still alive more than 20 years later. Under a "do or refer" regime supported by Compassion & Choices, people like Jeanette Hall would have their lives cut short by years or even decades as ethical doctors will be forbidden to use their professional judgment to encourage their suicide-minded patients to seek lifesaving treatment.

Moreover, once the concept of certain people having a right to assistance with their suicides to end their suffering is codified into law, there is no limiting principle to prevent it from being extended to other disabled people who also may claim to be suffering. If HB 6425 were enacted, further expansion will move into the hands of judges. While we in the disability-rights community view legalizing assisted suicide as a violation of the Americans with Disabilities Act and the disability equal protection clause (Article XXI, amending Article V) of the Connecticut

Constitution—people with certain disabilities are thus denied the benefit of suicide prevention services—judges could easily use both of these provisions to require extending the “benefit” of this “end of life option” to other disabled people. The limitations of “six months,” “terminally ill,” “mentally competent,” and “self-administer” in HB 6425 all discriminate on the basis of disability. Indeed, back in 1999, former Deputy Attorney General of Oregon David Schuman wrote [this response](#) to state senator Neil Bryant regarding the issue of self-administration:

“The Death with Dignity Act does not, on its face and in so many words, discriminate against persons who are unable to self-administer medication. Nonetheless, it would have that effect....It therefore seems logical to conclude that persons who are unable to self-medicate will be denied access to a ‘death with dignity’ in disproportionate numbers. Thus, the Act would be treated by courts as though it explicitly denied the ‘benefit’ of a ‘death with dignity’ to disabled people....”

Indeed, the Connecticut Supreme Court’s ruling in [State v. Santiago](#), striking down a prospective repeal of the death penalty in favor of full repeal, shows how our courts can expand laws beyond the intent of this legislature using equal protection grounds. The same principle is at work with HB 6425, which gives suicide assistance to some while others get suicide prevention, and the arbitrary difference is what disability they have.

So what about the person with ALS who has a six month prognosis, but has lost the ability to self-administer? What about the person with Parkinson’s disease, who will have tremors for years before dying? What about people with communication disabilities who may not be able to make the request on their own? What about Grandma with dementia, or the person with a severe psychiatric disability? Once the door to assisted suicide is pried open, Compassion & Choices will seek to open it further through the courts, going from six months terminal to one year, to perhaps five years; from assisted suicide to euthanasia; and from euthanasia for terminal illness, to chronic illness, to mental suffering. This is how we go down the same road as Canada, which is currently debating Bill C-7 to allow euthanasia even for non-physical conditions, and where [hospitals routinely deny treatment to disabled people while offering euthanasia instead](#). For Compassion & Choices, these are merely issues for another day, and for them, no less compelling.

Legislators and the public should not be fooled by a privileged lobby that seeks to sell suicide as a solution to their own disability-phobia. We should follow the recommendations of the National Council on Disability’s report, “[The Danger of Assisted Suicide Laws](#),” and reject codifying lethal and systemic disability discrimination into law.